IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA *ex rel.* JOSEPH "MICKEY" PARSLOW, Plaintiff, v. HCA – THE HEALTHCARE COMPANY, CURATIVE HEALTH SERVICES, INC., COLUMBIA MANAGEMENT COMPANIES, INC., PRESBYTERIAN/ST. LUKE'S MEDICAL CENTER, JFK MEDICAL CENTER, MEDICAL CENTER OSCEOLA, AVENTURA HOSPITAL AND MEDICAL CENTER, CENTRAL FLORIDA REGIONAL HOSPITAL, DOCTORS HOSPITAL OF SARASOTA, MEMORIAL HOSPITAL OF JACKSONVILLE, ST. PETERSBURG GENERAL HOSPITAL, NORTHWEST MEDICAL CENTER, NORTH FLORIDA REGIONAL MEDICAL CENTER, DEERING HOSPITAL, COLUMBIA KENDALL REGIONAL MEDICAL CENTER, OCALA REGIONAL MEDICAL CENTER, SOUTHWEST FLORIDA REGIONAL MEDICAL CENTER, ORANGE PARK MEDICAL CENTER, WESTSIDE REGIONAL MEDICAL CENTER, WEST FLORIDA REGIONAL MEDICAL CENTER, COLUMBIA HOSPITAL, FAWCETT MEMORIAL HOSPITAL, GULF COAST HOSPITAL, BRANDON REGIONAL HOSPITAL, TALLAHASSEE MEDICAL CENTER, REGIONAL MEDICAL CENTER BAYONET POINT, MEDICAL CENTER PORT ST. LUCIE, ENGLEWOOD COMMUNITY HOSPITAL, EASTSIDE COMMUNITY HOSPITAL, SAMARITAN MEDICAL CENTER, GREENVIEW REGIONAL MEDICAL CENTER, PARKLAND MEDICAL CENTER, PORTSMOUTH REGIONAL HOSPITAL, PROVIDENCE HOSPITAL, GRAND	Case No. 99-3338 (RCL) (Part of 01-MS-50 (RCL)) **COMPLAINT OF THE UNITED STATES** False Claims Act, 31 U.S.C. §§ 3729, *et seq*., and Common Law Causes of Action

STRAND REGIONAL MEDICAL CENTER,)
COLUMBIA MEDICAL CENTER WEST,)
SPRING BRANCH MEDICAL CENTER,)
COLUMBIA MEDICAL CENTER EAST,)
LAKEVIEW HOSPITAL, ST. FRANCIS)
HOSPITAL, ST. JOSEPH'S HOSPITAL,)
)
Defendants.)

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For its complaint, the United States of America alleges as follows:

I. NATURE OF THE ACTION

1. The United States brings this action to recover treble damages and civil penalties under the False Claims Act, 31 U.S.C. §§ 3729-33, to recover all available damages and other monetary relief under the common law or equitable theories of unjust enrichment, payment under mistake of fact, recoupment of overpayments, disgorgement of unlawfully earned profits, and for statutory restitution.

2. These claims are based upon false and fraudulent claims and false statements defendants made or caused to be made in hospital cost reports and claims submitted to Medicare for reimbursement of management fees paid by hospitals to defendant Curative Health Services, Inc. ("Curative"), and for services rendered to patients in Wound Care Centers ("WCCs") at hospitals owned, operated or managed by defendant HCA – The Healthcare Company or its predecessor companies (collectively "HCA") from January 1, 1993 through at least December 31, 1998.

3. On January 25, 2001, defendant Columbia Management Companies, Inc. ("CMC') pled guilty to one count of making false statements to the United States in a Medicare cost report filed by Brandon Regional Hospital located in Brandon, Florida, for the fiscal year ending December 31, 1995, in violation of 18 U.S.C. §§ 1001 and 1002. The Criminal Information to which defendant CMC pled guilty, and of the Stipulated Facts in support of the plea, are attached as Exhibit 1, and incorporated herein by reference.

4. The Criminal Information charged that CMC made false and fraudulent statements of material fact in a Medicare cost report that Brandon Regional Hospital submitted to the fiscal intermediary by stating that management fees paid to Curative were properly

reimbursable, when in fact those fees included the "substantial costs of the salaries and other compensation" paid by Curative to its Professional Liaison personnel whom CMC knew to perform advertising, marketing, and other functions that were not reimbursable by Medicare.

5. The United States alleges that defendants knowingly and fraudulently concealed, or failed to disclose, or caused others to fail to disclose material information in Medicare cost reports filed by hospitals that HCA owned, operated, or managed, in contravention of the hospitals' certifications that each cost report "is a true, correct, and complete report prepared from the books and records of the provider in accordance with applicable instructions," as required by federal law and regulation. 42 C.F.R. § 413.24(f)(4)(iv).

6. Claims for Medicare reimbursement of management fees paid to by hospitals to Curative were false because all defendants knew that the management fees included unallowable costs for marketing and advertising.

7. Claims for reimbursement of management fees paid to Curative by certain hospitals also were false because, contrary to each such hospital's certification, the payments violated the Federal health care program Anti-kickback Statute, 42 U.S.C. § 1320a-7b(b) ("Anti-kickback Statute"). Similarly, claims submitted for services rendered to Medicare beneficiaries on recommendation or arranged for by Curative were fraudulent.

8. As a result of defendants' false statements, false or fraudulent claims and false cost report submissions, defendants wrongfully obtained millions of dollars from Medicare that they were not entitled to receive.

9. The causes of action alleged herein are timely brought on the basis of the filing of relator's complaint in this action and when an official of the United States with responsibility to act under the circumstances knew or reasonably could know facts material to the right of action.

10. HCA and the United States have entered into a series of agreements under which HCA tolled and/or waived the statute of limitations and all related time-based defenses with respect to claims and potential claims of the United States stated against HCA and all of the HCA affiliated entities named as defendants herein.

II. JURISDICTION

11. The Court has subject matter jurisdiction over this action under 28 U.S.C. §§ 1331 and 1345 and supplemental jurisdiction to entertain the common law and equitable causes of action pursuant to 28 U.S.C. § 1367(a). The Court may exercise personal jurisdiction over the defendants pursuant to 31 U.S.C. § 3732(a) because at least one of the defendants resides or transacts business in the Middle District of Florida, the transferor Court, and because the agency to whom defendants submitted false claims is headquartered in this District. Moreover, 28 U.S.C. § 1407, necessarily confers the jurisdiction of the Middle District of Florida over the parties on this Court for this Multidistrict proceeding.

III. VENUE

12. Venue is proper in the Middle District of Florida, the transferor Court, under 31 U.S.C. § 3732 and 28 U.S.C. § 1391(b) and (c) because at least one of the defendants resides or transacts business in that District. Venue is proper in this District pursuant to 28 U.S.C. § 1407 because this action has been consolidated in this District for pre-trial proceedings.

IV. PARTIES

13. The United States brings this action on behalf of its agency, the Department of Health and Human Services ("HHS"), and its component, the Health Care Financing Administration ("HCFA"), which administers the Medicare Program.

14. Plaintiff and relator Joseph “Mickey” Parslow is a citizen of the United States and a resident of the State of Florida. From June 1994 to April 1999, Parslow was employed by defendant HCA in various capacities, including Chief Financial Officer of Fawcett Memorial Hospital, and Chief Financial Officer of Southwest Florida Regional Medical Center.

15. Defendant Curative is a publicly-traded Minnesota Corporation, headquartered at 150 Motor Parkway, Happauge, New York 11733. Prior to 1995, Curative was known as Curative Technologies, Inc. Curative provides services to hospitals that operate Wound Care Centers (“WCCs”). At all times relevant to this complaint, Curative also provided hospitals with Procuren, a proprietary wound-healing product made from the patient’s own blood at Curative’s laboratories.

16. Defendant HCA, formerly Columbia/HCA Healthcare Corporation, is a Delaware corporation that currently operates 189 hospitals and ancillary health care facilities in at least thirty states. During the time period relevant to this complaint, HCA operated over 400 hospitals in at least thirty-five states, including approximately 60 in Florida. HCA was formed on or about February 10, 1994, when Columbia Healthcare Corporation merged with defendant Hospital Corporation of America (“the original HCA”) . The merged company changed its name to HCA – The Healthcare Company on May 25, 2000.

17. Columbia Healthcare Corporation ("Columbia") was a Delaware corporation formed in July 1993, having its principal place of business in Louisville, Kentucky that owned, operated and managed hospitals in numerous states.

18. Columbia Hospital Corporation was incorporated on November 19, 1987 as a Texas Corporation, and reincorporated on July 26, 1990 as a Nevada corporation, with its principal place of business in Fort Worth, Texas. Columbia Hospital Corporation owned, operated and managed hospitals in several states.

19. Galen Health Care, Inc. ("Galen") was formed on or about February 12, 1993 as a Delaware corporation with its principal place of business in Louisville, Kentucky as a holding company for the 73 hospitals owned by Humana, Inc. Humana "spun off" Galen in March 1993. Galen is successor in interest to and responsible for the liabilities of Humana for those hospitals. Galen owned and operated hospitals in several states. Galen merged with Columbia in September 1993.

20. Hospital Corporation of America (the original HCA) was a Tennessee corporation with its principal place of business in Nashville, Tennessee. The original HCA owned and operated hospitals in numerous states. The February 1994 Columbia/HCA merger created the largest hospital chain in the United States.

21. HealthTrust, Inc. - The Hospital Company ("HealthTrust") was a Delaware corporation with its principal place of business in Nashville, Tennessee. HealthTrust owned and operated hospitals. A subsidiary of Columbia/HCA acquired HealthTrust on April 24, 1995.

22. Epic Healthcare Management Company was a Delaware corporation incorporated on or about September 30, 1988, and having its principal place of business in Dallas, Texas, that owned and operated hospitals.

23. Epic Healthcare Group, Inc. was a Delaware corporation formed on December 14, 1993 which, upon information and belief, became the parent to and responsible for the liabilities of, Epic Healthcare Management Company (collectively "Epic"). HealthTrust acquired Epic on May 5,1994.

24. As a result of these various mergers and acquisitions, HCA now owns hospitals formerly owned by the original HCA, Columbia, Galen, HealthTrust and Epic, located in the Middle District of Florida and elsewhere and is the successor in interest to and responsible for the liabilities of the original HCA, Columbia, Galen, HealthTrust and Epic and each of their hospitals.

25. HCA is liable in this action for the conduct of its predecessors; of each subsidiary between it and the hospitals and other entities it and its predecessors owned or operated as general or managing partner; and of the hospitals it and each of these predecessors owned or operated as general or managing partner. HCA is liable for that conduct directly, because it or its predecessors committed, participated in or caused the acts described herein, and derivatively, because it or its predecessors operated their various subsidiaries and hospitals as alter egos of the parent corporations. The United States alleges, on information and belief, that HCA and its predecessors: (a) created separate legal entities through which they owned or operated hospitals and other health care providers while dominating and controlling them all, operating them in an integrated manner, and disregarding the subsidiary corporations' basic corporate form; (b) shared

common ownership, board membership and management with their various subsidiaries, affiliates and hospitals; (c) shared corporate, group and divisional resources to perform operational, administrative, financial and reimbursement functions for their various subsidiaries, affiliates and hospitals; and (d) precluded the subsidiaries and affiliates from conducting business except that which was directed by and in the interests of the ultimate parent corporation. The United States alleges, on information and belief, that HCA and its predecessors historically operated various subsidiaries and affiliates as mere shell corporations through which corporate directives flowed to hospitals, and profits and other revenue flowed from hospital operations.

26. Defendant Columbia Management Companies Inc. ("CMC") is a Delaware corporation formed on December 31, 1996, which has its principal place of business in Nashville, Tennessee. Defendant CMC is a subsidiary of defendant HCA.

27. Attached as Exhibit 2, and incorporated herein by reference, is a chart listing the "Hospital Defendants" to this action. The Hospital Defendants are 38 hospitals currently owned by HCA that operate or operated WCCs managed by defendant Curative during a period in which HCA owned the hospital, managed the hospital as general or managing partner, or is the successor in interest to the corporation that owned, operated or managed the hospital during the relevant time period.

28. Attached as Exhibit 3, and incorporated herein by reference, is a chart listing all hospitals whose cost reports are at issue in this action, hereinafter the "HCA Hospitals." The HCA Hospitals are all hospitals that operated WCCs managed by defendant Curative during a period in which HCA owned the hospital, managed the hospital as general or managing partner, or is the successor in interest to the corporation that owned, operated or managed the hospital

during the relevant time period. The list of HCA Hospitals includes, therefore, the Hospital Defendants and hospitals which HCA no longer owns. To the extent HCA's liability for the conduct of those hospitals it no longer owns resides in other intermediate corporate entities, those entities will be identified in discovery and named as defendants to this action by amended complaint.

V. THE LAW

A. The False Claims Act

29. The False Claims Act (FCA) provides, in pertinent part that:

> (a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;. . . or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,
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> * * *
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person . . . .
>
> (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729(a) and (b).

B. The Anti-Kickback Statute

30. The Anti-kickback Statute prohibits any person from "knowingly and willfully" offering or paying "remuneration" in the form of a kickback, bribe, rebate or anything of value to induce the recipient to refer, arrange for, or recommend a health care item or service covered under a federal health care program. 42 U.S.C. § 1320a-7b(b)(2). The statute similarly prohibits solicitation and receipt of "remuneration" paid for those purposes. 42 U.S.C. § 1320a-7b(b)(1). The Anti-kickback Statute provides, in pertinent part,

> (1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind --
>
> > (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
> >
> > (B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,
>
> shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.
>
> (2) whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person --
>
> > (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

> (B) to purchase, lease, order or arrange for or recommend purchasing, leasing or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,
>
> shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

42 U.S.C. § 1320a-7b(b).

VI. THE MEDICARE PROGRAM

31. In 1965, Congress enacted Title XVIII of the Social Security Act ("Medicare" or the "Medicare Program") to pay for the costs of certain healthcare services. Entitlement to Medicare is based on age, disability or affliction with end-stage renal disease. See 42 U.S.C. §§ 426, 426A. Part A of the Medicare Program authorizes payment for institutional care, including hospital, skilled nursing facility and home health care. See 42 U.S.C. §§ 1395c-1395i-4. Most hospitals, including all HCA Hospitals whose claims are at issue in this action, derive a substantial portion of their revenue from the Medicare Program.

32. During that time period relevant to this complaint, Medicare paid for outpatient hospital services on the basis of the provider's reported costs. HCA and its hospitals operated WCCs as outpatient departments of the hospitals and were, therefore, reimbursed based on their costs.

33. HHS is responsible for the administration and supervision of the Medicare Program. HCFA, a division of HHS, is directly responsible for the administration of the Medicare Program.

34. To assist in the administration of Medicare Part A, HCFA contracts with "fiscal intermediaries." ("FIs") 42 U.S.C. § 1395h. FIs typically are insurance companies that provide a variety of services, including processing and paying claims and auditing cost reports.

35. During the course of their fiscal year, hospitals submit claims to their assigned FIs for reimbursement for the hospital stays for Medicare beneficiaries that they treat. 42 C.F.R. §§ 413.1, 413.60, 413.64. Hospitals receive interim payments on these claims. Within a specified time after the end of the hospital's fiscal year, the hospital must submit its cost report to its FI so that the FI can make year-end adjustments to the amounts paid to the hospital, as needed. 42 C.F.R. § 413.20(b).

36. Cost reports contain specific financial data relating to the hospital including reimbursable costs that the hospital expended to care for Medicare patients. Based on the cost report, Medicare determines whether the hospital is entitled to monies from Medicare in addition to the interim payments made during the year, or needs to reimburse any overpayments received during the year. 42 C.F.R. §§ 405.1803, 413.60 and 413.64(f)(1).

37. HCFA requires hospitals, as a prerequisite to payment by Medicare, to annually submit a form HCFA-2552, titled the "Hospital and Hospital Health Care Complex Cost Report".

38. The HCA Hospitals whose cost reports are at issue in this action were, at all times relevant to this complaint, required to submit cost reports to their FIs.

39. Every hospital cost report, contains a "Certification," which must be signed by the chief administrator of the hospital or a responsible designee of the administrator. 42 C.F.R. § 413.24(f)(4).

40. HCFA requires every hospital to certify that the filed cost report is (1) truthful, *i.e.*, that the cost information contained in the report is true and accurate, (2) correct, *i.e.*, that the hospital is entitled to reimbursement for the reported costs in accordance with applicable instructions, and (3) complete, *i.e.*, that the hospital cost report is based upon all of the provider's cost information pertaining to the determination of reasonable cost.

41. Each cost report prepared and submitted by HCA and the HCA Hospitals included a certification signed by the chief administrator or a responsible designee of the administrator, which states in pertinent part:

> to the best of my knowledge and belief, it [the Hospital Cost Report] is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

HCFA Form 2552-81. The cost report form also contained an explicit reminder to the provider that "intentional misrepresentation or falsification of any information contained in this cost report may be punishable by fine and or imprisonment under federal law."

42. Each cost report prepared and submitted by HCA and the HCA Hospitals after September 30, 1994 contained the following additional sentence:

> I further certify that I am familiar with the laws and regulations regarding the provision of healthcare services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

HCFA Form 2552-94.

43. Each cost report prepared and submitted by HCA and the HCA Hospitals during 1996 and thereafter contained the following additional notice:

> Misrepresentation or falsification of any information contained in this cost report may be punishable by criminal, civil and

> administrative action, fine and/or imprisonment under federal law. Furthermore, if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or were otherwise illegal, criminal, civil and administrative action, fines and/or imprisonment may result.

HCFA Form 2552-96.

44. All defendants are and were familiar with the Medicare law and regulations governing the Medicare Program, including requirements relating to the completion of cost reports.

45. At all times relevant to this action, the "applicable instructions" referenced in the hospital cost report certifications quoted above included the requirements (a) that hospitals seek reimbursement only for allowable costs, (b) that hospitals exclude unallowable costs, including advertising costs from the costs claimed as allowable, and (c) that the services described in the cost report complied with Medicare Program requirements, including the provisions prohibiting kickbacks, codified in 42 U.S.C. § 1320a-7b(b).

46. Under all versions of the cost report certification on HCFA Form 2552, hospitals were instructed to certify that the services provided in the cost report were not infected by a kickback.

47. HCFA's Provider Reimbursement Manual ("PRM") contains “applicable instructions” for the preparation of hospital cost reports; providers certify compliance with these instructions through the certifications quoted above.

48. As a general rule, only the costs of those items or services which are related to patient care are allowable for Medicare reimbursement. 42 C.F.R. § 413.9; PRM Part I §§ 2100, 2102.2.

49. Medicare reimburses management services at reasonable cost. PRM Part I § 2135.

50. Medicare requires a hospital seeking reimbursement for purchased management services to act as a "prudent and cost conscious buyer" of those services. PRM Part I § 2103.

51. When a hospital enters into a management agreement without seeking or evaluating competing offers, the hospital has a responsibility as a "prudent buyer" to ensure that the management fee does not become a vehicle to obtain reimbursement for unallowable costs. PRM Part I §§ 2135.3; 2135.4.

52. Certain advertising costs of a hospital are unallowable costs. PRM Part I § 2136.2. These unallowable costs include: (a) costs of advertising of a general nature designed to invite physicians to utlize a provider's facilities in their capacity as independent contractors; (b) costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities. Id. In the PRM, HCFA instructs providers that "General advertising to promote an increase in the patient utilization of services is not properly related to the care of patients." Id.

53. HCFA Form 2552 and HCFA's instructions for completing cost report forms require hospitals to collect and record cost data and patient utilization statistics in a manner designed to determine the true, reasonable, allowable cost that the hospital incurred to provide care to Medicare beneficiaries during the period covered by the report.

54. HCFA conditions the payment of Medicare funds during the year and at year-end on the hospital's certification that the statements contained in the cost report are true. 42 C.F.R. §§ 413.20(e), 413.24(f).

55. Shortly after receiving a hospital's year-end cost report, the FI makes a tentative settlement and payment of a hospital's cost report based on the data reported.

56. If a hospital discovers errors and omissions in its claims submitted for reimbursement to Medicare (including its cost reports), it is required to disclose those matters to its FI. 42 U.S.C. § 1320a-7b(a)(3) creates a duty to disclose known errors in cost reports:

> Whoever . . . having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment . . . conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized . . . shall in the case of such a . . . concealment or failure . . . be guilty of a felony.

VII. THE DEFENDANTS' SCHEME

A. Unallowable Advertising Costs Disguised as Management Fees

57. Beginning in or about 1990, Curative entered into management services contracts with the HCA Hospitals. Under these contracts, the hospital maintained an outpatient Wound Care Center (WCC) and provided space, equipment and hospital personnel, including clinic physicians and nurses and a medical director, to staff the WCC. Curative in turn was to provide certain management services to the WCC, employ a Program Director for each WCC and, for some hospitals, a Professional Liaison, and allow the hospital to use Procuren for a fee.

58. Beginning in at least 1993, Curative charged the HCA Hospitals a management fee that usually was comprised of a fixed monthly fee and a variable per patient or per visit fee. Frequently, fees of $400 to $2,000 per new patient were paid under the contracts only if the patient was "new to the hospital," as defined by the contract.

59. A substantial portion of the services that Curative provided to the HCA Hospitals under its management services contracts was marketing and advertising, sometimes referred to

by Curative as "community relations" or "community education," that had the express purpose of "generating patient referrals" and increasing patient utilization of the HCA Hospitals and WCCs.

60. Curative has described the objective of its purported "community education" plan as follows:

> To develop and implement a community plan and Center budget that will enhance new patient volume. By capitalizing on existing materials and services a Wound Care Center Program, in a minimum time frame, gains recognition and generates new patient referrals. The majority of these patients are new to the contracting hospitals' system.

61. Most of the contracts between Curative and the HCA Hospitals required that Curative and the hospital each contribute a specified sum of money to the WCC's marketing and advertising activities. These sums were used, *inter alia*, for media buys of television, radio and newspaper advertisements targeted towards the general public for the purpose of increasing patient volume. Under the management agreement, these sums were spent by Curative employees pursuant to an annual marketing plan, itself a deliverable under the contracts, prepared by the WCC Program Director and other Curative employees for each hospital's WCC and approved by that hospital's CEO.

62. Curative maintained a Marketing Department to assist hospitals and WCCs with marketing and advertising. Curative's Marketing Department reviewed and approved marketing plans, prepared and printed promotional materials to give to physicians and patients, and purchased advertising space and time.

63. In addition, Curative employees at its corporate headquarters, at its regional and/or divisional offices, and at the WCCs performed advertising and marketing activities.

64. One of the essential job responsibilities of the WCC Program Director during the time period relevant to this complaint was to market the WCC to increase patient utilization. Among other things, a Program Director was required to develop and manage the WCC's marketing plan and budget, make sales calls to physicians and other potential referral sources, schedule and conduct presentations and in-services to targeted groups, conduct ongoing inter-departmental and hospital medical staff marketing, develop and manage advertising and other promotional programs, and maintain communications with all referral sources.

65. During the time period relevant to this complaint, Curative based the size of its Program Directors' bonuses on the financial success of their WCCs.

66. Because the management fee included a variable per-patient fee, the Program Director's bonus was directly correlated to the success of marketing efforts to bring in increased numbers of patients.

67. Curative also provided several of the HCA Hospitals with "Professional Liaisons," known in the earlier years as "Marketing Representatives," to perform sales call and other marketing responsibilities. Professional Liaisons sometimes serviced more than one WCC. Professional Liaisons utilized data from the WCC regarding patient referrals to determine which physicians to call on with specific patient information and other materials. The Professional Liaison's bonus was directly related to the revenues generated by the WCCs.

68. During the course of a Medicare FI audit of St. Petersburg General Hospital, in April 1995, senior executives and reimbursement employees of Curative and HCA were advised that at least a portion of Curative's advertising and marketing expenses were unallowable costs.

69. At the time of the St. Petersburg audit and thereafter, Curative and HCA agreed not to disclose to the FI that additional costs associated with those unallowable activities were included in Curative's management fees.

70. In January 2001, defendant CMC stipulated to certain facts underlying its plea of guilty to the Criminal Information referenced in paragraphs 3 - 4, above. A copy of the Criminal Information and Stipulated Facts is attached as Exhibit 1.

71. CMC stipulated that 56 HCA Hospitals had contracts with an unnamed company to manage outpatient WCCs. The company referenced in the Stipulated Facts is Curative.

72. CMC stipulated that the HCA Hospitals submitted Medicare cost reports in which the hospitals stated and claimed that the fixed management fee and a variable fee paid to Curative were properly reimbursable under Medicare.

73. CMC stipulated that, in fact, personnel at the HCA Hospitals were aware that the Curative management fees claimed as allowable costs, like the fee Brandon Regional Hospital paid for the year ending December 31, 1995, included the substantial costs of the salaries and other compensation paid by the Curative to its Professional Liaison personnel.

74. CMC further stipulated that employees of the HCA Hospitals were aware that the services provided by Professional Liaison personnel, supervised by Program Directors, included unallowable advertising and marketing.

75. CMC further stipulated that HCA reimbursement employees also knew that the unallowable marketing and advertising costs associated with the salaries and benefits paid to Professional Liaison personnel were included in claims for reimbursement from Medicare, as part of cost report claims for reimbursement of management fees paid to Curative.

76. CMC stipulated that it knew that the HCA Hospitals' claims for reimbursement of Curative's management fees were false and fraudulent.

77. Curative charged the HCA Hospitals for its direct marketing and advertising services and for the compensation paid to its Program Directors and Professional Liaisons for their marketing activities (collectively "Marketing Costs") through the management fees that it charged the HCA Hospitals.

78. Curative knew that its Marketing Costs were unallowable costs under Medicare because they were intended to "generate referrals," to increase patient utilization and were not related to patient care.

79. Curative knew that the HCA Hospitals included its management fees on Medicare cost reports and, in most cases, did not identify some portion of those fees as unallowable costs.

80. HCA and the HCA Hospitals included Curative's management fees in cost reports that the HCA Hospitals submitted to Medicare, and identified them as allowable costs, although HCA and the HCA Hospitals knew that the management fees compensated Curative for its unallowable Marketing Costs.

81. Curative caused and enabled HCA and the HCA Hospitals to include Curative's management fees in their hospital Medicare cost reports by, *inter alia*, providing monthly invoices that did not segregate unallowable Marketing Costs.

82. Medicare reimbursed HCA and the HCA Hospitals for management fees paid to Curative, including unallowable Marketing Costs hidden in those management fees.

B. Illegal Kickbacks Disguised as Management Fees

83. Through a variety of means, including but not limited to its various marketing activities, its solicitations to referring physicians, its tracking of referrals from physicians, and its training and monitoring of physicians credentialed to practice in the WCCs, defendant Curative recommended the services of the HCA Hospitals to patients and physicians and arranged for patients to receive the services Curative recommended from those hospitals.

84. The services that Curative recommended and arranged for included services provided in the WCCs, and ancillary services, which defendants referred to at times as "spin off" services, that were reimbursable, and were in fact reimbursed, by Medicare.

85. Because the variety of maladies contributing to chronic non-healing of wounds appear most frequently in the population of Medicare beneficiaries, Curative's effort to recommend and arrange for services to be provided to wound care patients targeted Medicare beneficiaries and their physicians.

86. In negotiating its management fees with HCA and the HCA Hospitals, Curative regularly predicted the success of its efforts to recommend and arrange for services using a computer-generated pro forma that calculated the number of patients its activities would generate for a particular HCA hospital on an annual basis for several years into the future. Based on the expected acuity of those patients, Curative's pro forma estimated the services each patient would receive from the WCC directly, or in "spin off" or ancillary services, including inpatient admissions, from other departments of the hospital. The pro forma then estimated the revenue those WCC and "spin off" services would produce for the hospital, and identified specifically revenue from Medicare, usually estimated by Curative to account for 65% of the revenue received for those services.

87. The management fees that Curative solicited from and charged HCA and the HCA Hospitals, negotiated against this backdrop, including both a fixed and a variable component, were remuneration that Curative and certain of the Hospital Defendants, identified below, intended to be a payment to induce and reward Curative for recommending and arranging for the services of those Hospital Defendants to be provided to Medicare beneficiaries.

88. Throughout the time period relevant to this complaint, Curative, HCA and the HCA Hospitals were well-versed in the laws and regulations governing delivery of health care services, including those laws that prohibited the payment of kickbacks.

89. Knowing such conduct to be unlawful, defendants Southwest Florida Regional Medical Center, Brandon Regional Hospital, St. Petersburg General Hospital, Deering Hospital and, upon information and belief, other HCA Hospitals not yet known to the United States, paid management fees to Curative that the hospitals knew and intended to induce and to reward Curative for "generating referrals," *i.e.*, for recommending and arranging for services of those hospitals.

90. HCA and these Hospital Defendants submitted claims to Medicare, and included the cost of services on their Medicare cost reports, for services that Curative recommended and arranged for the patients to receive, and for which these Hospital Defendants paid Curative illegal kickbacks, in the form of variable fees for "new patients" as well as a fixed monthly management fee.

VIII. FALSE AND FRAUDULENT CLAIMS AND FALSE STATEMENTS

91. The cost reports for the HCA Hospitals and years listed in Exhibit 3, which is incorporated herein by reference, contained false claims for reimbursement, contained false

statements to Medicare regarding the allowable nature of the Curative management fees which defendants knew contained unallowable marketing and advertising costs, and in the case of Southwest Florida Regional Medical Center, Brandon Regional Hospital, St. Petersburg General Hospital, Deering Hospital and others, identified services for which the hospital had submitted fraudulent claims for interim payments based on the fact that services were provided in violation of the laws and regulations regarding the provision of health care services, specifically, the Anti-kickback Statute.

92. Exhibit 3 contains the following information regarding the hospitals and cost report years at issue in this action:

Column	Description
A	Hospital name
B	Hospital City
C	Hospital State
D	Medicare provider number
E	Cost report year-end
F	Hospital's Medicare fiscal intermediary
G	Name of each of the Wound Care Center(s) (WCCs) affiliated with each hospital
H	City where WCC was located
I	State where WCC was located
J	Dates of operation of the WCC

93. Cost reports submitted by the HCA Hospitals were, at all times relevant to this complaint, prepared by, or under the supervision of, employees of the Reimbursement

Departments of HCA (including its predecessors), with the assistance of hospital, Division and/or Regional officials.

94. Cost reports submitted by the HCA Hospitals were, at all times relevant to this complaint, signed by hospital officials or employees of HCA's Reimbursement Departments. The person who signed each cost report attested to the certification quoted above.

95. The cost reports listed at Exhibit 3 contained knowingly false certifications that the hospital's cost report was "a true, correct and complete statement prepared . . . in accordance with applicable instructions, except as noted."

96. The cost reports listed at Exhibit 3 were not prepared in accordance with applicable instructions governing the unallowable nature of advertising and marketing costs.

97. The cost reports listed at Exhibit 3 included claims for reimbursement of unallowable Marketing Costs as an allowable management fee, rendering the cost report a "false record or statement."

98. Curative, HCA and the HCA defendants knowingly caused the filing of the cost reports listed at Exhibit 3 which failed to disclose that the management fees paid to Curative included unallowable Marketing Costs as alleged in above.

99. Defendants Southwest Florida Regional Medical Center, Brandon Regional Hospital, St. Petersburg General Hospital, Deering Hospital and, on information and belief other HCA Hospitals, submitted cost reports indentified in Exhibit 3 that included claims for services recommended and arranged for by an entity that received kickbacks or illegal inducements prohibited by 42 U.S.C. § 1320a-7b(b) and/or other state and federal laws and regulations, thus rendering the cost reports a "false record or statement."

100. Certifications on those cost reports that "the services identified in this cost report were provided in compliance with such laws and regulations" referring to the laws and regulations regarding the provision of health care services were false.

101. In submitting cost reports, HCA and the HCA Hospitals concealed information relevant to whether they were entitled to payments for hospital services. Under these circumstances, the HCA Hospitals' certifications that each of their hospital cost reports was a "complete statement," were, in fact, false.

102. Moreover, the claims submitted by HCA and the HCA Hospitals that paid kickbacks to Curative for services rendered to Medicare beneficiaries on recommendation from, or arranged by, Curative were fraudulent claims.

103. In addition, Curative, HCA and the Hospital Defendants filed or caused to be filed Medicare cost reports that they knew contained untruthful or incorrect claims for reimbursement, contrary to the HCA Hospitals' certifications that the filed cost reports were true and correct to the best of their knowledge.

104. The hospital cost reports identified in Exhibit 3 were not prepared in accordance with applicable instructions despite defendant Curative's knowledge that its management fees included the costs of salaries and remuneration of Professional Liaisons, Program Directors, Marketing Department and other personnel who engaged in unallowable advertising and marketing services and, in some cases, kickbacks, and defendant Curative's further knowledge that its invoices enabled HCA and the HCA Hospitals to disguise the amount of the management fees attributable to unallowable advertising and marketing activities and, in some cases, kickbacks.

105. As alleged herein, all defendants engaged in a concerted effort and scheme to fraudulently obtain reimbursement for the HCA Hospitals from the Medicare Program to which the HCA Hospitals were not entitled.

106. These efforts involved the submission to the Medicare Program of claims for reimbursement of costs allegedly associated with the care rendered Medicare beneficiaries, which all defendants knew were not reimbursable under the rules and regulations governing the Program.

107. These submitted costs constitute false claims under the False Claims Act because the defendants knew they were not reimbursable under the rules and regulations governing the Medicare Program.

IX. DAMAGES

108. The United States was damaged because of the acts of defendants in submitting or causing to be submitted false or fraudulent claims, statements and records in that it was forced to reimburse the HCA Hospitals for unallowable Marketing Costs, and for illegal kickbacks that certain HCA Hospitals paid to defendant Curative.

109. The United States was damaged because of the acts of defendants in submitting or causing to be submitted false or fraudulent claims for interim payments for services recommended or arranged for by Curative at Southwest Florida Regional Medical Center, Brandon Regional Hospital, St. Petersburg General Hospital, Deering Hospital, and other of the HCA Hospitals in return for illegal kickbacks.

110. Defendants Curative, HCA and certain of the Hospital Defendants profited unlawfully from the payment of illegal kickbacks and unallowable Marketing Costs to Curative.

FIRST CAUSE OF ACTION

(False Claims Act: Presentation of False Claims)
(31 U.S.C. § 3729(a)(1))
(All Defendants)

111. Plaintiff repeats and realleges each allegation in ¶¶ 1 through 110, as if fully set forth herein.

112. All defendants, and each of them, knowingly presented or caused to be presented false or fraudulent claims for payment or approval to the United States.

113. By virtue of the false or fraudulent claims made by the defendants, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000 for each violation.

SECOND CAUSE OF ACTION

(False Claims Act: Making or Using False Record or Statement)
(31 U.S.C. § 3729 (a)(2))
(All Defendants)

114. Plaintiff repeat and realleges each allegation in ¶¶ 1 through 110, as if fully set forth herein.

115. All defendants, and each of them, knowingly made, used, or caused to be made or used, false records or statements to get false or fraudulent claims paid or approved by the United States.

116. By virtue of the false records or statements made by the defendants, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000 for each violation.

THIRD CAUSE OF ACTION

(False Claims Act: Reverse False Claims)
(31 U.S.C. § 3729(a)(7))
(All Defendants)

117. Plaintiff repeats and realleges each allegation in ¶¶ 1 through 110, as if fully set forth herein.

118. All defendants, and each of them, knowingly made, used or caused to be made or used a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the United States.

119. By virtue of the false records or statements made by the defendants, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000 for each violation.

FOURTH CAUSE OF ACTION

(False Claims Act Conspiracy)
(31 U.S.C. § 3729(a)(3))
(All Defendants)

120. Plaintiff repeats and realleges each allegation in ¶¶ 1 through 110, as if fully set forth herein.

121. Curative, HCA and the HCA Hospitals, agreed to submit the false claims, statements and records identified herein.

122. By virtue of the false or fraudulent claims made by defendants, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000 for each violation.

FIFTH CAUSE OF ACTION

(Unjust Enrichment)
(All Defendants)

123. Plaintiff repeats and realleges each allegation in ¶¶ 1 through 110, as if fully set forth herein.

124. This is a claim for the recovery of monies by which the defendants have been unjustly enriched.

125. By directly or indirectly obtaining government funds to which they were not entitled, all defendants were unjustly enriched, and are liable to account and pay such amounts, or the proceeds or profits therefrom, which are to be determined at trial, to the United States.

SIXTH CAUSE OF ACTION

(Payment By Mistake)
(HCA and the Hospital Defendants)

126. Plaintiff repeats and realleges each allegation in ¶¶ 1 through 110, as if fully set forth herein.

127. This is a claim for the recovery of monies paid by the United States to the defendants by mistake.

128. The United States, acting in reasonable reliance on the accuracy and truthfulness of the information contained in the cost reports submitted by HCA and the HCA Hospitals, paid the Hospital Defendants and the other HCA Hospitals identified in Exhibit 3 certain sums of money to which they were not entitled, and HCA and the Hospital Defendants are thus liable to account and pay such amounts, which are to be determined at trial, to the United States.

SEVENTH CAUSE OF ACTION

(Common Law Recoupment)
(HCA and the Hospital Defendants)

129. Plaintiff United States repeats and realleges each allegation in ¶¶ 1 through 110, as if fully set forth herein.

130. This is a claim for common law recoupment, for the recovery of monies unlawfully paid by the United States to the Hospital Defendants and the other HCA Hospitals identified in Exhibit 3 contrary to statute or regulation.

131. The United States paid the Hospital Defendants and the other HCA Hospitals identified in Exhibit 3 certain sums of money to which they were not entitled; HCA and the Hospital Defendants are thus liable under the common law of recoupment to account and return such amounts, which are to be determined at trial, to the United States.

EIGHTH CAUSE OF ACTION

(Restitution for Program Liaison Expenses)
(HCA and Columbia Management Companies, Inc.)

132. Plaintiff United States repeats and realleges each allegation in ¶¶ 1 through 110, as it fully set forth herein.

133. The United States has suffered a lost of at least $2,275,000 as a result of violations of 18 U.S.C. §§ 1001 and 1002 to which defendant CMC pled guilty in the Middle District of Florida on January 25, 2001. Mandatory restitution for that loss was reserved for resolution in this matter. HCA and its subsidiary CMC are thus liable to the United States under the common law and in equity to account for and return those sums, which are to be determined at trial, as restitution to the United States.

NINTH CAUSE OF ACTION

(Common Law Fraud)
(HCA and the Hospital Defendants)

134. Plaintiff repeats and realleges each allegation in ¶¶ 1 through 110, as if fully set forth herein.

135. HCA, the Hospital Defendants and the other HCA Hospitals made material and false representations in their filed hospitals cost reports with knowledge of their falsity or reckless disregard for their truth, with the intention that the government act upon the misrepresentations to its detriment. The government acted in justifiable reliance upon those misrepresentations by settling HCA Hospital cost reports at an inflated amount.

136. Had the true facts been known to plaintiff, HCA, the Hospital Defendants and the HCA Hospitals would not have received payment of the inflated amounts.

137. By reason of its inflated payments, plaintiff has been damaged in a yet undetermined amount.

TENTH CAUSE OF ACTION

(Disgorgement of Illegal Profits,
Imposition of a Constructive Trust and an Accounting)
(All Defendants)

138. Plaintiff repeats and realleges each allegation in ¶¶ 1 through 110, as if fully set forth herein.

139. This is a claim for disgorgement of profits earned by HCA, the HCA Hospitals and Curative because of, on the one hand, illegal kickbacks that certain HCA Hospitals paid to Curative and, on the other, the unallowable Marketing Costs for which HCA and the HCA Hospitals submitted claims for Medicare reimbursement.

140. Defendant presented or caused to be presented statements, reports and claims for payment to the United States knowing such statements, reports and claims to be false, fictitious, or fraudulent.

141. HCA and the HCA Hospitals made such false, fictitious or fraudulent statements, reports and claims to the United States to conceal the illegal kickbacks and unallowable Marketing Costs they paid to Curative.

142. HCA, the HCA Hospitals, and Curative earned illegal profit from business generated as a result of unallowable advertising and marketing activities and, in the case of certain hospitals, illegal kickbacks.

143. The United States, acting in reasonable reliance on the accuracy and truthfulness of these representations, did not detect defendants' illegal conduct.

144. This Court has the equitable power to, among other things, order Curative, HCA and the Hospital Defendants, to disgorge the entire profit defendants earned from business generated as a result of their violations of the Anti-kickback Statute and the False Claims Act.

145. By this claim, the United States requests a full accounting of all revenues (and interest thereon) and costs incurred by HCA, the HCA Hospitals and Curative, disgorgement of all profits earned from the WCCs at HCA Hospitals and/or imposition of a constructive trust in favor of the United States on those profits.

PRAYER FOR RELIEF

WHEREFORE, the United States demands and prays that judgment be entered in favor of it as follows:

1. On the First, Second, Third and Fourth Causes of Action under the False Claims Act, against all defendants for the amount of the United States' damages, trebled as required by law, and such civil penalties as are required by law, together with all such further relief as may be just and proper.

2. On the Fifth Cause of Action for unjust enrichment against all defendants, for the damages sustained and/or for an accounting and disgorgement of amounts by which defendants were unjustly enriched plus interest, costs, expenses, and such further relief as may be just and proper.

3. On the Sixth and Seventh Causes of Action for payment by mistake and recoupment of overpayments against HCA and the Hospital Defendants, for the damages sustained by the United States, plus interest, costs, expenses, and such further relief as may be just and proper.

4. On the Eighth Cause of Action, for restitution against HCA and CMC, for the losses sustained by the United States.

5. On the Ninth Cause of Action, for fraud against HCA and the HCA Defendants, for compensatory and punitive damages, together with costs and interest, and for such further relief as may be just and proper.

6. On Tenth Cause of Action, for disgorgement against all defendants, for an accounting and disgorgement of the profits defendants obtained illegally, plus interest, costs, and expenses, and such further relief as may be just and proper.

Respectfully submitted,

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